Artemis Domiciliary Care Limited

Artemis Domiciliary Care Ltd

Inspection report

Amtech House
Samson Close
Newcastle Upon Tyne
Tyne And Wear
NE12 6DX

Tel: 01913403660

Date of inspection visit:
02 November 2016
03 November 2016

Date of publication:
09 December 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Artemis Domiciliary Care Ltd (Newcastle) provides personal care and support to people living in their own homes. At the time of our inspection there were 30 older people using the service who had physical, sensory or mental health related conditions.

This inspection took place on 2 and 3 November 2016 and was announced. This was the first comprehensive inspection of the service since its registration in February 2015.

The service had a registered manager in post who was also the registered manager of another of the provider's services based in Carlisle. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager operated the service on a daily basis. This was overseen by the registered manager who kept in daily contact with the service.

People told us they felt safe living at home with support from their care workers. Staff understood their responsibilities to report safeguarding concerns to the deputy manager or registered manager. People and staff told us they felt there were enough staff employed to provide a reliable and consistent service. We confirmed this through records.

There had been no accidents and only four incidents were recorded at the service; these were documented and forwarded on to relevant parties as appropriate, although formal analysis had not yet taken place to monitor patterns or trends.

The service had risk assessed general aspects of people's daily living to ensure their safety, however the risk assessment documentation was generic and each person's risk assessment contained the same risks and control measures. We discussed this with the deputy manager and registered manager who told us they would improve these documents and make them person specific. We have made a recommendation about this. The company policies and procedures had been recently reviewed and updated to support staff with the safe and effective running of the service.

Overall medicines were managed well. We found a small issue with the records involving topical medicines. People told us they had no issues with their medicines support and care workers told us they felt competent with this task. No incidents or near misses had occurred with regards to medicines support. Care workers had completed a safe handling of medicines training course and formal medicine competency checks were carried out.

The service had a good recruitment process in place; however, we found that in the three records we examined, gaps in applicants' employment history had not been explored. The registered manager told us they would add this check into the interview process to prompt recruitment staff to explore this area

thoroughly through discussion, making recruitment checking more robust. This had been implemented by the end of the inspection.

Staff received a company induction upon commencement of employment which included a briefing on company policies and procedures. However, in the three records we examined there was no evidence that a common induction package such as the 'Care Certificate' had been implemented in a timely manner. We discussed this with the registered manager who was able to provide evidence of other staff who had completed the Care Certificate. All staff had undertaken a mixture of face to face and online training courses throughout their employment. We found the process to ensure that all new staff had their skills and competence formally assessed, before carrying out their role unsupervised was not robust.

Formal staff supervision sessions, including shadowing shifts, a probationary review, one to one meetings and annual appraisals had all taken place. All staff had been spot checked during an unannounced visit from a team leader and plans were in place to conduct these periodically. Staff meetings were held every three months with the care workers and monthly management meetings took place. The staff we spoke with told us they felt supported and valued by the management team.

Evidence showed the registered manager and staff had an understanding of the Mental Capacity Act (MCA) and their own responsibilities. The service used the local authority's mental capacity assessments within their records. Care records showed that wherever possible people had been involved in making some decisions, but significant decisions regarding people's care were made in people's best interests and had been taken appropriately with other professionals and relatives involved.

People told us they were respected and their dignity and privacy were maintained. All of the staff we spoke with displayed kind and caring attitudes and through discussion, they told to us how they respected people's privacy and dignity.

People told us they received a responsive service from care workers who were familiar with their needs and preferences. However, we found support plans were not always person centred and the records we examined did not contain a sufficient level of detail about individual people to reflect a personalised service. People's care needs were briefly recorded but did not always have a corresponding support plan or an individual risk assessment. Reviews were regularly carried out by the management team with input from people, their families and external healthcare professionals; however, care records were not always updated with any changes. We have made a recommendation about this.

People told us they were offered a choice in all aspects of the support they received and care workers told us they obtained verbal consent before providing any support. People and their relatives told us they had nothing to complain about but they knew how to complain and would feel confident to do so, if necessary. The service had received one complaint which we saw was being managed appropriately.

All of the staff told us they worked very well as a team. Care workers felt extremely well supported by the deputy manager who they described as approachable, caring and someone who made them feel like a valued member of the team. People, relatives and staff all described the service as "Excellent".

The deputy manager told us they gathered feedback from people and relatives through regular contact on the telephone and when visiting people at home to update paperwork. Formal satisfaction surveys were carried out every six months which we saw portrayed positive results. The feedback we gathered as part of the inspection was very good from everyone we contacted. The service has not yet formally sought the views of its staff. The registered manager told us they would do this in the near future.

A robust system was not in place to thoroughly monitor all aspects of the service, including quality and safety. The issues we identified during the inspection highlighted this. We have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments were drafted to support staff to protect people from harm. However, we found these were generic and required some attention to ensure they were individualised and person specific.

Staff understood their responsibilities to safeguard people from harm and abuse and they were aware of how to respond to any suspicions of abuse.

A safe recruitment procedure was in place and pre-employment vetting checks were carried out.

Medicines were managed safely and people told us they received the right medicine at the right time.

Is the service effective?

Good

The service was effective.

Staff were trained in relevant topics including those specific to individual needs.

Staff were well supported by the management team through supervision, appraisal and spot checks to ensure they remained skilled and competent within their roles.

Staff had a good understanding of the Mental Capacity Act and its associated principles. People had consented to their care and support.

People were supported to eat and drink well and they had appropriate access to external healthcare professionals.

Is the service caring?

Good

The service was caring.

People gave us overwhelmingly positive feedback about the service. They told us their care workers were kind, caring and

friendly.

People told us both themselves and their homes were respected and that their privacy and dignity was upheld.

Care workers were aware of people's individuality and adhered to their choices and preferences.

Is the service responsive?

Good

The service was responsive.

People told us they received care which was tailored to their needs and wishes. The service was flexible and adapted to meet people's changing needs although the records did not reflect this.

People had their care and support reviewed at regular intervals. Care records were not always updated to reflect the current arrangements.

The people we spoke with told us they had no complaints at all but were aware of how to complain and had confidence that the management team would resolve any issues.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Care records were not always accurate and contemporaneous. Support plans were brief and risk assessments were generic.

Audits and checks of the records had not highlighted the issues we identified during the inspection.

Care workers were very happy in their role and felt appreciated and valued by the management team.

The service sought the views of people and had tried to develop aspects of the service to improve the issues people and staff faced.

Artemis Domiciliary Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 2 and 3 November 2016 and was announced. We gave the provider short notice of the inspection to ensure there would be staff available at the provider's office to access records. The inspection was conducted by one adult social care inspector.

Prior to the inspection we reviewed all of the information we held about Artemis Domiciliary Care Ltd, including whether any statutory notifications had been sent to us by the provider and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

As part of the inspection, we contacted three people who used the service by telephone to gather their opinions. We also spoke with one relative to acquire their feedback about the service. We spoke with eight members of staff, including the deputy manager, a senior care worker, three care workers, an administrator, the registered manager and the registered provider. We reviewed a range of care records and other records related to the quality and safety management of the service. This included looking at three people's care records and three staff files.

Additionally, we contacted Newcastle City Council local authority commissioning team and their adult safeguarding team to obtain their feedback about the service. On this occasion, we asked for a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this

information informed our planning of the inspection.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe with support from their care team. Comments received included, "Yes, very safe" and "We wouldn't go anywhere else." We asked a relative if they felt their relation was safe and they told us they did.

People's general needs had been risk assessed and risk assessments were drafted to support staff with their duty of care. We saw these risk assessments were not person specific and generic risks to aspects of people's health, wellbeing and daily living such as medicine, mobility and their home environment were repeatedly recorded in each person's record. Risk assessment documentation detailed possible hazards and strategies to prevent incidents; however, these were identical in each record and not applicable to all people. We discussed this with the deputy manager and registered manager who told us they would ensure an individual risk assessment was carried out and irrelevant information would be removed. Risk assessment training for senior staff was not being routinely carried out or refreshed to ensure current guidelines and best practices were followed. The registered manager told us this training would be sourced and provided to senior care staff as soon as possible.

We recommend the service seeks advice and guidance from a reputable source regarding individual risk assessment documentation and training.

Safeguarding policies and procedures were in place for staff to follow in order to protect people from harm or improper treatment. There had been no accidents and four incidents of a safeguarding nature within the service. We saw these had been appropriately recorded and responded to. The registered manager had referred onto the local authority as necessary. Staff had completed a safeguarding of vulnerable adults training course and were able to describe their responsibilities to report safeguarding matters. Staff told us they were not concerned about anybody they looked after. They understood all of the policies and procedures in place and told us they would have no hesitation to report any concerns to the management team.

The provider had an up to date business continuity plan in place and we were able to review it. The plan contained information to support staff and ensure the service could still operate in the event of a crisis, such as a fire, flood or IT failure. Other aspects of the service such as staff shortages and extreme weather conditions were appropriately planned for, with emergency arrangements and alternative plans clearly documented.

The service operated an electronic call monitoring service. This meant people were further protected because care workers 'logged in' on arrival at people's homes. This ensured visits to people were not missed. It also made sure staff were safer when working alone as office staff were able to track their whereabouts and a system was in place to monitor when staff returned home after a shift.

People, relatives and staff told us there were enough staff employed by the service to meet people's needs with a reliable and consistent service. Comments included, "I always get someone I know", "I have an

alternate team who work back to back", "I have a good team" and "It's [the service] very consistent." A relative told us, "You can rely on them; we are never worried that they won't turn up." We reviewed the staff rotas and saw care workers were allocated regular shifts with the same people to visit each day/week. There were gaps in the rotas for care workers to have breaks and travelling time was factored into their schedules. The care workers we spoke with confirmed they did not feel hurried in their duties.

Recruitment procedures were in place to ensure staff were suitable to work with vulnerable adults. We examined three staff records and found a recruitment process had been followed. Staff files contained evidence of an application for employment; however gaps in applicant's employment history had not been explored. This meant the registered manager could not assure herself that a thorough vetting check has been completed. The registered manager told us she would add a check of this information to the interview process to ensure recruitment staff thoroughly explored this area in future through a discussion with applicants. We saw evidence of this amendment in the interview record before the end of our inspection.

Competency based interviews had taken place, two references were obtained and verified and a check with the Disclosure and Barring Service (DBS) was carried out. DBS checks ensure staff have not been subjected to any actions that would bar them from working with vulnerable people. Employers use these checks to help them make safer recruitment decisions. A company induction, shadowing of experienced staff and on-going training was all in place. This demonstrated that the registered manager safely recruited staff with a variety of skills and experience and checked that they were of suitable character to meet the needs of the service. The staff we spoke with confirmed these checks were completed prior to their employment.

The registered manager carried out return to work interviews following periods of sickness and the provider had a disciplinary policy and procedure in place for when staff fell short of expectations. This showed that the registered manager continued to ensure staff were suitable to work with vulnerable people.

We checked how the service managed people's medicine needs. People told us they received their medicines on time and as prescribed. The deputy manager told us, "Carers are mostly [verbally] prompting people to take their medicines." There was strict guidance in place for the staff to follow with regards to the ordering, receipt, storage and disposal of any medicine. The service had ensured people's medicines were stored safely in 'dossette box' filled by a pharmacist. This meant people could access their own medicine independently without fear of getting their tablets mixed up. Separate medicine risk assessments were not in place. However, generic risks around medicines support were contained within the risk assessment documentation. Specific risks, such as why a person's medicines were locked in a safe, or the administration of medicines with special instructions, were not explained in the records we examined. However, a care worker told us, "Special instructions are usually highlighted on the MAR so they stand out." We asked the registered manager to consider these individual examples when redrafting risk assessments. The care workers we spoke with were aware of these individual risks and supported people as required.

Care workers signed a Medicine Administration Record (MAR) to show when support had been given. We reviewed some MAR's and saw they were legible and well maintained. We noted that when care workers supported people with topical medicines, there were no instructions written on the MAR or care plan about the area of the body that the topical medicine should be applied to. Topical medicines are described as creams, gel or ointment, that are applied to the surface of the skin. Some care workers had recorded this information in their daily notes, but not all. When we highlighted this anomaly to the deputy manager, they told us they would ensure care workers used a body map section already printed on the MAR to record this information in the future. MAR's were audited by the deputy manager or a team leader on a monthly basis. The deputy manager told us any discrepancies which surrounded medicines were reported to the office immediately. We noted there had been no issues with the management of medicines and no concerns or

errors had been reported.

Good

Is the service effective?

Our findings

A relative described the team as, "Very effective carers". They added, "If I need advice about anything or things I'm worried about, they will help you". People told us, "I'm very confident in them" and "They know what they are doing, they use the equipment properly."

Training had been delivered to care workers via face to face courses or online, in topics which the provider deemed mandatory such as safeguarding vulnerable people, moving and handling of people, health and safety, food hygiene and infection control. Other key topics such as continence care were resourced for people with specific needs. External professionals such as nurses had delivered training on invasive care procedures such as PEG feeding. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a feeding tube is placed through the abdominal wall and into the stomach to allow nutrition, fluids and/or medicines to be put directly into the stomach, bypassing the mouth and oesophagus. Staff had the opportunity to enrol in qualifications in Health and Social care at level two and three, depending on their role to enhance their personal development. All members of the management team were working towards or had achieved nationally recognised qualifications at a higher level.

The deputy manager used a training matrix to record the dates when staff training was completed so they could monitor when refresher training was appropriate. Unannounced spot checks had been carried out by the team leaders to ensure staff delivered high standards of care. There was a plan in place to conduct these checks every three months and implement a periodic medicine competency check.

We saw in staff records that staff had undergone an induction into the company which covered the policies, procedures and operational activity of the service. It also included shadowing of experienced staff. There was no evidence that a robust common induction package such as the 'Care Certificate' had been completed by these three staff in the first 12 weeks of their employment. After the inspection the registered manager told us that all staff (without previous care experience) were supposed to complete the 'Care Certificate' induction process and she sent us evidence of other staff who had completed it. The Care Certificate is a benchmark for the induction of staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. This demonstrated that there was a gap in the system which had been set up to ensure staff had the skills and competence to carry out their role before they were allowed to work unsupervised. The three staff whose files we examined had not undertaken the care certificate as they should have done, but they had completed online awareness courses in relevant topics.

The training matrix also highlighted that none of the care workers had undertaken training in dementia care despite a lot people using the service having this need. The administrator told us she would immediately add this topic to the online training account to ensure staff completed it. Following the inspection, the registered manager provided us with an up to date induction presentation pack and the process for enrolling staff onto the care certificate as evidence to show that no staff would be missed in the future.

A probationary period was in place for new staff and this was monitored and reviewed at regular intervals by

the deputy manager or registered manager. Supervision sessions took place every three months following a successful probationary period. These sessions included discussions around company objectives, training needs and a development plan. Other aspects of the job role were reviewed such as 'service user' issues, mobility plans, uniform, timekeeping and compliance with electronic call monitoring. Any performance issues or concerns were summarised with an action plan and a timescale for improvement. Six monthly 'on the job' supervisions were in place and annual appraisals had also been carried out as necessary. Staff told us they thought these sessions were beneficial. One care worker said, "You can bring anything up, you get good feedback. It makes you feel good about your job and that you are valued and appreciated." This demonstrated the registered manager prepared staff for the role, provided continuous support and ensured competence was maintained.

The staff we spoke with told us they felt fully supported in their role and confirmed that they had undertaken relevant training which enabled them to be confident when assisting people with support. One care worker said, "The training was good, I definitely feel equipped to do the job."

Care worker team meetings took place every three months. The provider and the deputy manager had conducted the last staff meeting which included discussing scenarios, sharing ideas, information and lessons learned from incidents which had occurred at this service and at the providers other registered location. A care worker told us, "Communication is really good, best one [company] I have worked with."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service relied upon the local authority's community mental health care team to provide capacity assessments and inform them of people's mental health needs upon referral. The registered manager told us that where people lacked the mental capacity to make particular decisions they had been supported by their relatives and external health and social care professionals to make decisions in their best interests. The service had not been involved in any formal best interests' decision-making meetings.

We discussed how the service ensured people had the capacity to consent to their care and treatment. We were told that the service would refer a person to the community mental health team if there were any doubt about the mental capacity of someone they supported. The deputy manager told us some people's relatives had a Lasting Power of Attorney (LPA), although they were unsure if this arrangement was for health and welfare, finances or both, as they had not seen the documentation. An LPA is a way of giving someone (usually a relative) the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. The deputy manager said in future she would ask relatives if they would provide a copy of the LPA documentation to evidence that they had the right to make these decisions on behalf of their relative. One person's finances were in the process of being managed by the local authority under Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time because they may lack capacity to do so. After this arrangement is finalised, the service will liaise with the local authority to ensure the person has enough food, clothing and bills are paid.

The service was supporting people to maintain good nutrition and hydration. The people we spoke with had no concerns about the support they received with this. We saw evidence in care records that the service had assessed people's nutrition and hydration needs and the daily notes demonstrated staff supported people to eat healthy, well balanced meals. There was additional evidence in daily records that where necessary food and fluid intake was recorded by staff in order to be monitored by external professionals such as GP's,

nurses and dieticians.

Care records showed the service involved external health and social care professionals when people's needs changed. The records indicated that staff had made referrals to GP's, district nurses and occupational therapists. Records were made of the communication and any progress or outcomes were recorded. A relative confirmed they were kept abreast of any communication between or involvement of external professionals. They said, "I can rely on them to do what is necessary." One person told us, "I was struggling with the rotunder [standing aid], so they helped me get a hoist."

Good

Is the service caring?

Our findings

It was apparent from the conversations we had with people that they enjoyed an excellent relationship with their care workers. Comments included, "I get a good laugh with them, all my family likes them too", "They are all nice, friendly people", "(Care worker) is a born carer, she goes beyond the normal, I really appreciate it", "They do a brilliant job" and "I would have no hesitation to use them for more services." A relative confirmed the positive feedback, adding, "We are extremely happy with the service" and "They are all genuinely nice human beings".

The service was very accommodating of people's needs. We saw evidence in office records and through discussion found that the service was flexible to suit people's needs and wishes. Visits were re-arranged to make them more convenient for people who had appointments. Care workers were allocated to visits based on people's expressed preferences. A relative told us, "Nothing is too much trouble for anyone." The service had recorded 21 compliments. One compliment read, "I'm overwhelmed by the support given."

The staff we spoke with demonstrated caring and compassionate attitudes when we discussed people's care needs, their role and the tasks they supported people with. Another compliment read, "(Care worker) is very good at her job, she is very pleasant and always has a smile on her face."

Discussions with the management and care workers revealed that people who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. Training records showed staff had completed an awareness course in this topic.

Care records showed people and their relatives had been involved in the care planning process. They had contributed to the information recorded about themselves such as likes, dislikes, interests and hobbies. People or relatives had been asked to sign the documentation to consent to the agreed care and support.

We reviewed a 'Service User Guide' and an up to date 'Statement of Purpose' which the service had produced and shared with people who used the service. These documents contained information about the company's values and the limitations of service. They explained what the 'service user' can expect from the company and how the service will be delivered. They provided information on quality assurance, complaints and useful contacts. Some of the company's policies were also included for people's information such as staff conduct, health and safety and confidentiality.

At the time of the inspection nobody who used the service required an advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The registered manager told us that relatives usually acted in this role and sometimes the deputy manager or a care worker assisted people. The registered manager told us they were aware of how to involve an independent advocate from the local authority if required.

Care records which contained people's sensitive information were kept locked away at the office and copies were available in people's homes for care workers to access. Care workers had completed an awareness course in respecting privacy and dignity. They demonstrated to us how they implemented this training into their role. The staff we spoke with were aware of the importance of maintaining confidentiality and privacy. Care workers told us how they maintained people's dignity and gave us examples, such as closing doors and blinds and keeping intimate areas of the body covered over during personal care tasks. People and a relative confirmed this and told us all staff treated them and their homes with respect. One person said, "I am very comfortable in their presence."

Care workers supported people to maintain their independence and they told us about encouraging people to do some tasks for themselves, supporting only when necessary. At the time of the inspection the service was supporting one person with end of life care. The staff were aware of and held records of 'Do Not Attempt Resuscitation' orders where people had shared this with information with them. The service also provided telecare equipment such as monitored personal emergency alarms, to people who purchased this additional provision to enable them to continue living safely at home.

Good

Is the service responsive?

Our findings

The people we spoke with told us they received a personalised and responsive service. They felt their individual needs were met and their care workers were very familiar with their routines, preferences, likes and dislikes. One person said, "They [office staff] come out every two to three months and check everything is OK and they look at the paperwork." A relative told us the care workers who visited his wife knew her very well. He said, "I have no cause for concern, my wife must have no stress and they respect that." The care workers we spoke with demonstrated that they knew individual people very well. During discussions they displayed a good knowledge of people's individual preferences. One care worker said, "Anything we need is in the book [care record]." This showed that people received a person-centred service.

We reviewed three support plans which had been drafted to provide guidance for care workers to safely and effectively assist the people they visited. We found these support plans and the associated risk assessments were not person-centred or specifically detailed to reflect individual needs. They lacked sufficient personalised details such as preferences, routines, life history, family, hobbies and interests, likes and dislikes in order for a care worker to understand and familiarise themselves with the person before visiting. One of the three records briefly mentioned a person enjoyed walks and reading. The deputy manager told us people had been reluctant to share this level of detail during the assessment. They were able to show us other support plans which did contain more detail. The deputy manager told us they would try to acquire more personal information about people to ensure all records had a similar level of detail.

People's care needs had been assessed but were briefly documented. For example, one record noted a person required assistance with meal preparation, catheter care and medicine administration. There was no support plan drafted for meal preparation or catheter care and there was a briefly written support plan in relation to their medicine needs. This meant staff were not provided with full written instructions around the support required and how an individual would prefer the support to be delivered. Through discussion with care workers and a cross check of the MAR and the daily notes we found evidence that the person had received appropriate care and treatment. Despite the lack of documentation, this person's relative told us that care workers delivered safe and effective care which met their relative's needs.

We recommend the service takes a more person centred approach to care planning and that team leaders and care workers contribute to reviewing documentation in order to provide thorough personalised details about individuals.

The deputy manager told us they reviewed people's care after an initial period and conducted telephone reviews after 12 weeks. The management team were responsible for reviewing and updating care plans and assessments, and there was evidence that people, their relatives and external professionals all had input into this. Review meetings were held in people's homes to ensure people who used the service were involved in the process and they could invite whoever they wished to attend the meeting. We saw evidence of joint reviews taking place with the local authority social services department, with outcomes and actions recorded. Some actions included involving specialists such as occupational therapists to provide advice and guidance on the best use of equipment when people were struggling to manage with the equipment they

had. Annual reviews took place, as did reviews when needs changed, however, we found that support plans were not always updated when changes occurred. The registered manager told us that this would be promptly addressed.

Care workers described to us how they ensured people were given choice and control over all aspects of their care. They said, "We go in and ask people what they want. For example, we might ask about food, drinks, clothing and toiletries. Usually people have a set routine but we always check." People told us they could choose if they preferred a male or female care worker and the service had respected other choices such as what time people liked to get up and what time they liked to go to bed."

The service had received one complaint which was on-going. The deputy manager had escalated the complaint to the registered manager who was in the process of conducting investigations in order to respond to the complainant. We saw an acknowledgement had been made in a timely manner and the complaints process was being followed correctly. The deputy manager told us they dealt with smaller issues immediately, which could be resolved easily over the telephone or by making a visit to the person.

A complaints policy and procedure was in place and had been shared with the people who used the service via the 'service user guide' and 'statement of purpose'. The people and relatives we contacted during the inspection had no complaints about the service, the care workers, or the management team. Everyone was very complimentary about the service. Comments included, "No complaints at all, no cause for concern", "You cannot fault them", "I've nothing to complain about, sometimes (deputy manager) comes out and she rings me to see if everything is OK", "I've never complained about anything" and "I would just ring them if I had a problem."

Requires Improvement

Is the service well-led?

Our findings

The deputy manager was in charge of the service upon our arrival and assisted us throughout the inspection with the help of the administrator. They liaised with care workers and the people who used the service on our behalf. The registered provider was on site during the inspection and the registered manager travelled across from the provider's other service in Carlisle to be present in the afternoon and for feedback.

Some audits and formal checks on the safety and quality of the service were being carried out. We saw evidence of an audit of care records was contained at the front of the files we examined; however, the registered manager had not identified the shortfalls we highlighted in risk assessment documentation such generic risk assessments as the omission of individual risk assessments of people's specific needs.

There was evidence of staff records being checked for completion, however, the issue we found with gaps in employment history had not been identified or addressed prior to our inspection. Training had not been robustly monitored; this had allowed some staff to continue working without completing a formally assessed common induction package, such as the Care Certificate. This meant the registered manager had not assured herself that all new care workers were competent to carry out their role prior to being allowed to work unsupervised.

Through our conversations with a team leader, we noted there was no formal record of the out of hour's service. The senior care workers and team leaders worked on a rota basis covering the service outside of normal office hours. They told us they verbally told each other what had occurred during a handover process between shifts or text information to each other via a mobile phone. We discussed this with the deputy manager and registered manager who confirmed there was no written record of communications with people and staff outside of office hours. The deputy manager told us the staff text her whilst she was off duty with anything important that she needed to know. We asked the registered manager to consider the implementation of a 'handover' book to ensure important information passed between staff on differing shifts is recorded and that information is signed for when actioned to confirm who has taken responsibility for addressing the issues raised. The registered manager agreed this would ensure staff were accountable for their actions and responsibilities. We saw this was implemented by the end of our inspection.

We recommend the provider develop a robust quality assurance system to ensure all aspects of the service of thoroughly monitored.

The deputy manager told us that they had recently set up a new system with support from the administrator. A new matrix was in place to monitor the return of people's MAR's and daily notes. These records were randomly checked for care workers compliance with record keeping. The administrator was also in the process of inputting support plan and risk assessment dates onto the matrix in order to monitor when reviews were due for completion.

Although accidents, incidents and safeguarding matters were low and recorded appropriately, due to the low number they had not yet been formally analysed for patterns or trends. The registered manager told us

they had planned to devise a tool to monitor these and would do so in the near future. She did confirm that the deputy manager emailed her and the provider with statistics on a daily basis about any incidents and events to ensure they all had oversight of the service. Monthly management team meetings also took place to discuss the quality and safety of the service. We saw an action plan drafted after a meeting contained actions, responsibility and a timescale for completion.

The registered manager and deputy manager had extensive experience of working with adults in a domiciliary care setting. The deputy manager had progressed through the organisation to her current role. The deputy manager was very knowledgeable about the people who used the service and had provided personal care and support to everyone who currently used the service.

There was a clear staffing structure in place, which included the registered provider, the registered manager, a deputy manager, an administrator, two team leaders, two senior care workers and 20 care workers. The whole team were aware of their responsibilities and what they were accountable for. The care workers worked regular shifts which were consistent for both them and the people who used the service. The care workers we spoke with told us they had no issues at all with the management of the service. Policies and procedures were in place, they had been reviewed in 2016 with a view to an update every two years.

The culture of the service was open and transparent. People, relatives and staff that we spoke with described the service as "Excellent." One care worker said, "(Deputy manager) is very supportive, really good. You can pop in the office and speak with them at any time, about anything." Another said, "There is really good support, I do feel valued – they are constantly praising us and telling us the clients appreciate us." A member of the office staff told us, "(Provider name) is really good with the staff, they gave us money to take six care workers out for a meal who had helped out loads."

We asked care workers if they enjoyed their job. One said, "It's a really good job, I love my job, there is total job satisfaction." Another said, "It's an enjoyable job, it doesn't feel like work." They added, "The work-life balance is good, you get scheduled days off but can do overtime if you choose."

The registered manager told us they prided themselves on being able to choose carefully which care packages they take on, which enabled them to support people with good, consistent and reliable care. She said the deputy manager "bends over backwards" for the staff and she gets good results from a good team. A care worker said, "(Deputy manager) phones you up and tells you compliments that people have passed on, which is nice." The deputy manager added that they liked to cover care now and again, to visit people and resolve any "little niggles". They liked the personal touches, they said, "It gives you pleasure."

The service had sought the views of people by sending out a satisfaction survey every six months. Opinions of people were also gathered at a six month review of their care package. Feedback about the service was overwhelmingly positive with the odd comment about care workers running late on occasions. The service had not yet formally sought the views of their staff but the registered manager told us they had recently conducted a staff survey at their other registered service and could implement the same at this service straight away. Staff had an opportunity to raise and discuss issues that were important to them during their private supervision sessions and at team meetings.

We were informed of some of the challenges of running the agency. This included recruitment of good staff and travelling distances for care workers. The deputy manager told us about strategies the company had tried to attract good care workers into the business including a higher rate of pay, guaranteed hours, travelling costs and paying for DBS certificates. The registered manager also told us they were considering investing in a 'pool' car to alleviate some of the difficulties when care workers were absent at short notice or

had trouble with their own vehicles. This demonstrated the provider listened to the views of staff and people and attempted to resolve issues that were important to them.